Medicaid Pathway Information Gathering Process
Stakeholder Feedback and State Response November 3, 2016

Stakeholder Comment	State Response
Vermont Model of Care	
Model of Care elements are inconsistently delivered and not equitably available across regional and culturally diverse populations.	*One of the primary goals of the initiative is to support the statewide adoption of the Model of Care, thereby improving the care experience for all program participants throughout the State.*
Trauma-informed care is a missing element to the Model of Care.	*The Model of Care outlines key elements for how providers work together to better integrate care and effectively address individualized care needs. Model of Care elements (including person/family-centered planning, development of comprehensive care plans and use of an interdisciplinary care team) will dictate care delivery that is responsive to individual/and or family needs and reflective of best practices (e.g., trauma-informed care, early intervention, prevention and wellness).*
Elements that allow for the proper integration of mental health and health supports are missing.	*The Model of Care is intended to support active and multi-disciplinary planning and coordination of all health services. The State looks forward to working with stakeholders to ensure that the model includes the appropriate tools to support full integration.*
Peer supports are insufficient and inconsistent across geographic and culturally diverse populations and should be a critical component of comprehensive, coordinated care.	*The second element in the Model of Care is "Access to Independent Options Counseling and Peer Support." The Model of Care recognizes the importance of peer support to promote person-centered and directed care planning. Access to peer supports is important that the model should promote uniform availability of this service for all populations.*
Delivery System – Governance and Collaboration	
Agencies have not adopted an agreed upon regional shared decision-making model.	*The current proposal does not require shared-decision making structures but rather outlines the elements that must be present if providers, at their discretion, decide to formally organize at the local level.*
Proposed DA/SSA Payment Model	
Using easy and available data to measure population outcomes may steer towards measuring the wrong indicators of payment.	*Quality and outcome monitoring relies on a broad set of measures and not all measures will be tied to payment. We agree that the final selection of measures used to create payment-related incentives will need to be vetted thoroughly.*

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The bundled payment methodology does little to facilitate integrating care because the existing funding silos are retained in the proposed groupings or cohorts.	*We understand that many enrollees have complex needs that cross service domains (e.g., an adult with developmental disability service needs and who may also need substance use disorder treatment services). We are reviewing feedback to determine what rate model adjustments and service delivery requirements best support integrated care.*
Artificial caps wouldn't work; moving towards a PPS-2 design of clinical cohorts in a bundled payment approach may break down existing barriers to a truly integrated Model of Care.	*We continue to review feedback and intend to continue to collaborate with stakeholders to develop a reform approach that best meets individual needs within available resources and promotes a high-quality, sustainable delivery system.*
It was requested to see the full modeling and information on all of the inputs beyond agency audits.	*Modeling is based on audited financials, claims, MSR, and other data, some of which is identifiable. Vermont has scheduled several meetings with providers to review data pertinent to their practices and services. The State is willing to schedule additional one-on-one meetings with de-identified information as needed.*
The DVHA portion of DA income should be rebased.	*We will continue to review feedback and will continue to collaborate with stakeholders.*
The proposed model must be aligned with the All-Payer Model and other reform initiatives.	*We agree and understand that this will be an iterative process to prepare for fuller integration overtime. The current All-Payer Model agreement calls for a plan to be submitted to CMS by the end of year three (2020) for the coordination of financing and community based delivery of behavioral health with the APM targets.*
DCF and the Agency of Education should participate in Medicaid Pathway Discussions as they provide significant funding.	*The Agency of Education has very specific mandates regarding IEP-required service and Medicaid. Additionally, Success Beyond Services in the schools rely on local school board approval of funding for these contracts While we agree that all dollars should be reviewed in any total cost of care calculation, it does not appear feasible at this time to re-define the local payment mechanism between the schools and DA's.* *DCF is involved in internal discussions. We expect to engage both partners more fully as the reforms become more defined.*

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Grants should not be included in the payment model.	*We are reviewing all Medicaid payments, whether through grants (e.g. VISION payment system) or the claims processing system. Final decisions on which services to include in the final Medicaid payment model are pending.* *We do not anticipate including non-Medicaid grant payments in the first phase of development, however as more modern IT and payment tracking systems are developed this may be a possibility.*
DS should be excluded from any capitation methodology.	*Thank you and we will take this feedback under consideration.*
Other services suggested to include in Phase One: SASH, Blueprint, SNAP, housing vouchers, and behavioral interventions in schools.	*Thank you and we will take this feedback under consideration.*
Concerns about how any global budget would involve the 50% of DS clients who have co-occurring conditions.	*Thank you we will take this feedback under consideration.*
Quality Framework	
The National Network of Family Support and Strengthening Network's evaluations of family voice/family leadership in system change tools should be utilized.	*Thank you and we will explore how these resources can be used.*
Interested in viewing the impact of services for clients with the highest needs and measure that estimate the prevention of more costly services.	*We believe that payment and system delivery reform creates an opportunity to ensure person/family centered, community-based care that reduces the need for more costly services.*
Phasing	
The full vision/model must be completed before phasing implementation can be possible.	*The final vision is a fully aligned, organized and integrated health care system of care for all persons. The current All-Payer Model agreement calls for a plan to be submitted to CMS by the end of year three (2020) for the coordination of financing and community based delivery of behavioral health with the APM targets. We fully expect that lessons learned from each phase will be used to systematically improve the design and quality of service delivery in future years.*